Emergency Services Training
CERTIFICATION EXAM REQUEST

Complete all information on this form and return to Emergency Services Training at least **thirty (30) days** prior to the requested examination date.

This request is for: ☐ Initial Exam ☐ Written Exam ☐ Manipulative Skills Exam
☐ Retest Exam – *If retest, date when initial exam was taken:* _____

➤Before a test will be scheduled, a minimum of five (5) candidates is required. If less than five (5) candidates, contact EST for other available options.

Department, Location, and Exam Information

_____
Department name

Examination requested: *(Separate requests required for each exam level requested)*

☐ Driver/Operator-Pumper
☐ Fire Fighter I
☐ Fire Fighter II

Examination requested to be conducted at:

_____ _____ _____ _____
Written Exam date requested | Start Time | Manipulative Skills Exam date requested | Start Time

_____ _____
Location/Building where written exam will be given | Location/Building where manipulative skill exam will be given

_____ _____ _____ _____
Street address | City | State | Zip

Exam Requested By:

_____ _____ _____
Chief or Training Official Signature | Chief or Training Official Name (typed or printed) | Date

Written Test Facility Verification

I verify that the facilities used during this testing event ensures the health and safety of the participants and meets or exceeds the applicable NFPA safety and health standards or their equivalent.

_____ _____ _____
Chief or Administrator Signature | Chief or Administrator Name (typed or printed) | Date

_____ _____ _____ _____
Department Mailing Address | City | State | Zip

Manipulative Skills Test Facility Verification

I verify that the facilities and equipment used during this skill testing event ensures the health and safety of the participants. I also verify that the testing site, personal protective equipment, apparatus, and equipment used during the testing event meet the requirements of all applicable NFPA standards or their equivalent.

_____ _____ _____
Chief or Administrator Signature | Chief or Administrator Name (typed or printed) | Date

_____ _____ _____ _____
Department Mailing Address | City | State | Zip

➤Up to three (3) attempts for the written exam will be provided within one (1) year of the initial written exam date.
➤This form must be completed, signed, and returned at least **thirty (30) days** prior to the requested exam date to:

Emergency Services Training
PO Box 83720
Boise, ID 83720-0095

Revised 12/2004
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